

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION**

IN RE: Bridgeport Health Care Center, Inc., of Bridgeport, CT
d/b/a Bridgeport Health Care Center
600 Bond Street
Bridgeport, CT 06610

CONSENT ORDER

WHEREAS, Bridgeport Health Care Center, Inc., (hereinafter the "Licensee"), has been issued License No. 2061-C to operate a Chronic and Convalescent Nursing Home known as Bridgeport Health Care Center, (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter the "FLIS") of the Department conducted unannounced inspections on various dates commencing on December 17, 2007 and concluding on December 20, 2007.

WHEREAS, the Department, during the course of the aforementioned inspections identified, violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated January 14, 2008 (Exhibit A – copy attached); and

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Rachel Blass, its President, hereby stipulate and agree as follows:

1. The Licensee shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Consent Order. The INC's duties shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur the cost associated with the INC.

Licensee: Bridgeport Health Care Center, Inc., of Bridgeport, CT.

2. The INC shall function in accordance with the FLIS's INC Guidelines (Exhibit B - copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut and who is credentialed in wound care. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
3. The INC shall provide consulting services for a minimum of six (6) months at the Facility unless the Department identifies through inspections that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations. The INC shall be at the Facility forty (40) hours per week and arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends. The Department will evaluate the hours of the INC at the end of the six (6) month period and may, in its discretion, reduce or increase the hours of the INC and/or responsibilities, if the Department determines the reduction or increase is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order.
4. The INC shall have a fiduciary responsibility to the Department.
5. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within two (2) weeks after the execution of a contract with the Licensee.
6. The INC shall confer with the Licensee's Administrator, Director of Nursing Services, Medical Director and other staff determined by the INC to be necessary to the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations.
7. The INC shall make recommendations to the Licensee's Administrator, Director of Nursing Services and Medical Director for improvement in the delivery of direct patient care in the facility. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination, which shall be binding on the Licensee.
8. The INC shall submit weekly written reports to the Department documenting:
 - a. The INC's assessment of care and services provided to patients;
 - b. The Licensee's compliance with applicable federal and state statutes and regulations; and

Licensee: Bridgeport Health Care Center, Inc., of Bridgeport, CT.

- c. Recommendations made by the INC and the Licensee's response to implementation of the recommendations.
9. Copies of all INC reports shall be simultaneously provided to the Director of Nurses, Administrator, Medical Director and the Department.
10. The INC shall have the responsibility for:
- a. Assessing, monitoring, and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, and nurse aides and implementing prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
 - b. Conducting training, providing oversight to nursing staff, provide consultation regarding implementation of a mechanism to monitor weekly pressure sore statistics, observe all pressure sores, monitor preventative protocols and assess patients at risk for pressure sores and/or vascular sores.
 - c. Reviewing all potential admissions to determine if the Facility is capable of meeting the needs of the prospective patient;
 - d. Assessing, monitoring, and evaluating the coordination of patient care and services delivered by the various health care professionals providing services;
 - e. Inservicing staff pursuant to infection control principles and practices;
 - f. Evaluation of staff on a routine basis, on all three shifts, regarding the implementation of infection control protocols;
 - g. Recommending to the Department an increase in the INC's contract hours if the INC is unable to fulfill the responsibilities within the stipulated hours per week; and
 - h. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letter dated January 14, 2008 (Exhibit A).
11. The INC, the Licensee's Administrator, and the Director of Nursing Services shall meet with the Department every six (6) weeks for the first six (6) months of this Consent Order and thereafter at twelve (12) week intervals throughout the tenure of the INC. The meetings shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations.

Licensee: Bridgeport Health Care Center, Inc., of Bridgeport, CT.

12. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the INC and the Department, upon request.
13. The Department shall retain the authority to extend the period the INC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.
14. Within fourteen (14) days of the execution of this Consent Order the Director of Nurses shall develop and/or review and revise, as necessary, policies and procedures related to physical assessment of patients with pressure ulcers, pressure ulcer prevention and treatment, documentation and tracking of pressure ulcers, care planning, interventions pertinent to pressure ulcers, assessment and care planning for patients that utilize splints, and turning and repositioning of patients.
15. Within twenty-one (21) days of the effect of the Consent Order nursing staff shall be inserviced, regarding the policies and procedures identified in paragraph number fourteen (14).
16. A Registered Dietitian Consultant shall be employed or contracted with for a minimum of thirty (30) hours per week.
17. The Facility's medical staff shall review all policies and procedures related to skin integrity and treatment.
18. The primary physician shall examine patients' pressure sores during each required visit and document the findings.
19. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Director of Nursing Services, shall ensure substantial compliance with the following:
 - a. Sufficient nursing personnel are available to meet the needs of the patients;
 - b. Patients are maintained, clean, comfortable and well groomed;
 - c. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
 - d. Patient assessments are performed in a timely manner and accurately reflect the condition of the patient;

Licensee: Bridgeport Health Care Center, Inc., of Bridgeport, CT.

- e. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
 - f. Nurse aide assignments accurately reflect patient needs;
 - g. Each patient's nutritional and hydration needs are assessed and monitored in accordance with his/her individual needs and plan of care;
 - h. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, decline in skin integrity, presence of any infection, and deterioration of mental, physical, nutritional, and/or hydration status. In the event that the personal physician does not adequately respond to the patient's needs or if the patient requires immediate care, the Medical Director is notified;
 - i. Patient's with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;
 - j. Necessary supervision and assistive devices are provided to prevent accidents;
 - k. Policies and procedures related to dehydration prevention shall be reviewed and revised to include, in part, notification of the attending physician or medical director when the patient's fluid intake does not meet their assessed needs; and
 - l. Patient injuries of unknown origin are thoroughly investigated, tracked, and monitored.
20. Effective upon the execution of this Consent Order, the Licensee shall appoint a free floating Registered Nurse Supervisor on each shift whose only responsibility is the assessment of patients and the care provided by nursing staff. The nurse supervisor shall maintain a record of any patient related issue(s) or problem(s) identified on his or her shift and a notation as to the subsequent action taken to resolve the problem(s). Such records shall be made available to the Department upon request and shall be retained for a three (3) year period.
21. Individuals appointed as Nurse Supervisor shall be employed by the Facility or if contracted shall consistently be assigned to the Facility. Nurse Supervisors shall not carry a patient assignment and shall have previous experience in a supervisory role.
22. Nurse Supervisors shall be provided with the following:

Licensee: Bridgeport Health Care Center, Inc., of Bridgeport, CT.

- a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;
 - b. A training program which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to patient and staff observations, interventions and staff remediation;
 - c. Nurse Supervisors shall be supervised and monitored by a representative of the Licensee's Administrative Staff, (e.g. Director of Nursing Service or Assistant Director of Nursing Service) to ensure the Nurse Supervisors are functioning in accordance with this Consent Order and state and federal requirements. Said administrative supervision and oversight shall be provided on all three (3) shifts on an irregular schedule of visits. Records of such administrative visits and supervision shall be retained for the Department's review; and
 - d. Nurse Supervisors shall be responsible for ensuring that all care provided to patients by all caregivers is in accordance with individual comprehensive care plans.
23. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe.
24. The Licensee shall establish a Quality Assurance Program (QAP) to review patient care issues including those identified in the January 14, 2008 violation letter. The members of the QAP shall meet at least monthly to review and address the quality of care provided to patients and, if applicable, implement remediation measures. Membership shall at a minimum, include the Administrator, Director of Nurses, Infection Control Nurse, Nurse Supervisors, and the Medical Director. Minutes of the QAP meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.
25. In accordance with Connecticut General Statute Section 19a-494 (a) (5), the license of Bridgeport Health Care Center is placed on probation for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
26. The Licensee shall pay a monetary penalty to the Department in the amount of twelve thousand dollars (\$12,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the

Licensee: Bridgeport Health Care Center, Inc., of Bridgeport, CT.

effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

Lori-Ann Griffin
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

27. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
28. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
29. The terms of this Consent Order shall remain in effect for a period of two years (2) years from the effective date of this document unless otherwise specified in this document.
30. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
31. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

Licensee: Bridgeport Health Care Center, Inc., of Bridgeport, CT.

WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

BRIDGEPORT HEALTH CARE CENTER, INC.,
OF BRIDGEPORT, CT. - LICENSEE

070108
Date

By: Rachel Blass
Rachel Blass, its President

STATE OF CONNECTICUT)

County of FAIRFIELD) ss BRIDGEPORT 2008

Personally appeared the above named RACHEL BLASS and made oath to the truth of the statements contained herein.

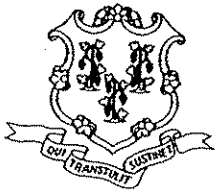
My Commission Expires: 01/31/2013
(If Notary Public)

June Crall
Notary Public ☒
Justice of the Peace ☐
Town Clerk ☐
Commissioner of the Superior Court ☐

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

July 3, 2008
Date

By: Joan D. Leavitt
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 32

January 14, 2008

Mr. Christopher Massaro, Administrator
Bridgeport Health Care Center
600 Bond Street
Bridgeport, CT 06610

Dear Mr. Massaro:

Unannounced visits were made to Bridgeport Health Care Center on December 17, 18, 19 and 20, 2007 by a representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for January 24, 2008 at 1 PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Lori Ann Griffin, SNC

Lori-Ann Griffin, SNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

LAG:hh

c. Director of Nurses
Medical Director
President
Complaint # CT7277, CT7388



Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(L) and/or (k) Nurse Supervision (1).

1. Based on clinical record reviews and interviews with staff for two of nineteen sampled residents (Resident #60 and Resident #206), with pressure ulcers the facility failed to notify the physician and/or family members when the resident experienced a change in condition. The findings include:
 - a. Resident #60 was admitted to the facility on 10/3/07 from an acute care hospital with diagnoses that included dehydration, urinary tract infection, multiple MRSA infected pressure sores and other open areas that were debrided and required treatment with intravenous (IV) Vancomycin. The resident's admission minimum data set (MDS) dated 10/10/07 identified the resident required assistance with hygiene and bed mobility. Wound assessments dated 10/3/07 identified the following pressure sores: stage IV on the left lateral leg, stage IV on the coccyx, stage II on the left achilles area, stage II on the right posterior leg, stage II on the right hip, and healing bilateral heel pressure sores. A care plan dated 10/3/07 identified an alteration in skin integrity and directed staff to provide treatment to the wounds, apply pressure-relieving devices to the bed and chair and turn and reposition every two hours. Weekly wound assessments identified the coccyx pressure sore increased in size from 5 centimeters (cm) x 7 cm x 1 cm on 10/3/07 to 11.5 cm x 10.3 cm x 0.8 cm on 10/17/07. Between 10/3/07 and 10/23/07 the coccyx pressure sore was identified with 50% slough and not necrotic. Review of the resident's clinical record with the Director of Nurses (DNS) on 12/19/07 at 1:40 PM lacked evidence that the physician or the family were notified of the increase in size of the pressure sores. The facility policy identified that a deterioration in a pressure sore as a change in condition and for staff to notify the physician and family when a resident experienced a change in condition. On 10/29/07 Resident #60 was admitted to an acute care hospital and a physician assessed the coccyx pressure sore as having a large amount of black necrotic tissue extending to the fascia. In addition, Resident #60's admission MDS dated 10/10/07 identified the resident required assistance with eating. A Dietitian's assessment dated 10/4/07 identified the resident required 1700 to 1800 cubic centimeters (cc) of fluids daily. Between 10/4/07 and 10/25/07 Resident #60's fluid intake was below 1000 cc on 12 occasions and only attained 1700 cc or more on one occasion. A facility policy for intake and output monitoring directed to notify a physician if a resident's intake was below the daily-recommended fluid goals for three consecutive days. Review of Resident #60's clinical record failed to reflect that the physician was notified of the poor fluid intake. On 10/25/07 Resident #60 was seen by a Gastroenterologist and directed nothing by mouth in preparation for a feeding tube insertion on 10/26/07. Following the feeding tube insertion, orders directed not to administer feedings to the resident via the tube for 24 hours. However, the resident's

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

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STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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- fluid needs for hydration were not addressed. Resident #60 experienced low fluid intakes of 900 cc of oral fluids on 10/25/07, 250 cc of fluids via an enteral feeding tube on 10/26/07, and 650 cc of fluids via an enteral feeding tube on 10/27/07. Review of the clinical record failed to provide evidence that the physician was notified of the resident's low fluid intakes. Interview with physician (MD) #2 on 12/19/07 at 12:45 PM identified that, despite the resident's low fluid intake, he was not notified of any specific instance where the resident's fluid intake was poor, but only received general reports of the resident's total intake being poor. MD #2 identified he was not notified on 10/26/07 or 10/27/07 that Resident #60's fluid needs were not met. MD #2 further identified that he would have ordered IV fluids had he been notified that the resident did not meet daily fluid goals. On 10/29/07 Resident #60 was admitted to the hospital for treatment of acute renal failure secondary to severe volume depletion and sepsis with a Blood Urea Nitrogen (BUN) of 229 (normal 6-20), Sodium level of 163 (normal 136-145) and Creatinine level of 7.2 (normal 0.4-1.1). Upon arrival to the hospital, Resident #60 was unresponsive and required cardiopulmonary resuscitation and intubation.
- b. Resident #206's diagnoses included paraplegia and hypertension with a history of a non-healing Stage IV pressure sore on the coccyx. The resident's Minimum Data Set (MDS) dated 10/18/06 through 10/3/07 identified some cognitive deficits and the need for assistance with activities of daily living. Resident #206 was admitted to an acute care hospital between 4/9/07 and 4/16/07 and returned to the facility with a new Stage II pressure sore on the left heel. On 6/8/07 Resident #206 was identified with a pus-filled pressure sore on the right heel. Review of the right heel pressure sore flow sheets identified on 6/8/07 the ulcer was a 6 cm x 2 cm pus filled blister that improved by 7/26/07 to 3.5 cm x 3 cm with granulation tissue evident. However, between 8/3/07 and 10/5/07 the pressure sore was identified as a stage IV that was necrotic and foul smelling. Review of Resident #206's clinical record failed to reflect that Resident #206's family was notified of the new stage II left heel pressure sore identified on 4/16/07, was not notified of the new stage II right heel pressure sore identified on 6/8/07 and failed to reflect that Resident #206's family was notified when the right heel pressure sore progressed from stage II to a stage IV. Interview with the DNS on 12/19/07 at 1:40 PM identified that the clinical record lacked evidence that Resident #206's family was notified of the right or left heel pressure sores. Resident #206 was evaluated at a wound clinic on 10/9/07 and identified with gangrene of the right foot, admitted directly to an acute care hospital and had a right below the knee amputation. Interview with MD #1 on 12/20/07 at 10:40 AM identified that he had could not recall what was communicated to him, could not recall if he had assessed Resident #206's right heel pressure sore, and in review of the resident's clinical record, identified that he had not written any progress notes regarding the resident's pressure sore.

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

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STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administration (3)(D) and/or Connecticut General Statutes 19a-550.

2. Based on clinical record reviews, observations and interviews for one of eight sampled residents who required total assistance for eating (R #116) and/or for one of three sampled residents with behavior symptoms (R #346) and/or for one sampled resident who received a physical examination (R #24), the facility failed to ensure care was provided to enhance the residents' dignity. The findings include:
- Observation on 12/18/07 at 11:30 AM identified R #24 sitting in a wheelchair in the hallway. Further observation noted Medical Doctor (MD) #3 with a stethoscope in his ears and the bell positioned on the resident's chest. After listening to the heart, MD #3 proceeded to palpate both the resident's breasts and stated, "I am checking for lumps". The physician then palpated the resident's abdomen. At the time, several other residents were noted nearby in the hallway. An interview with MD #3 at the time indicated that his usual practice was to conduct physical examinations in the resident's room to afford privacy.
 - Resident # 116's diagnoses included cerebral vascular accident with left sided hemiparesis. A significant change Minimum Data Set (MDS) dated 10/18/07 identified impaired cognition and total assistance for eating. The care plan dated 10/18/07 identified self-care deficits with interventions that included providing total care for bathing and eating. Observation on 12/19/07 at 11:20 AM noted the resident in bed with a soiled face and several egg particles covering the front of the resident's johnnie. Interview with Nurse Aide (NA) # 5 on 12/19/07 at 11:20 AM identified morning care had not yet been provided. Although NA #5 indicated the resident was positioned lower in the bed after breakfast, the resident's face was not washed and food particles that had fallen onto the resident's johnnie gown during breakfast were not removed.
 - Resident #346's diagnoses included schizophrenia, diabetes mellitus and hyperthyroidism. An admission Minimum Data Set (MDS) dated 10/09/07 identified the resident with long and short term memory problems, moderately impaired cognitive skills, resistive to care, and independence for ambulation. A care plan dated 10/18/07 identified alteration in mood state with interventions that included responding promptly to needs, attentive listening, one to one visits, and direct resident concerns to the appropriate discipline. Observation of the resident on 12/17/07 from 5:30 AM through 7:10 AM identified the resident roaming around the unit without purpose and entering and exiting multiple residents' rooms. Further observations identified the resident was wearing a johnnie coat that opened at the back. The resident was noted to have an incontinent brief with the back fully exposed from top to bottom. Staff was noted to ignore the state of undress until 5:50 AM when Licensed Practical Nurse (LPN) #6 provided a johnnie to cover the resident's back. In addition, the resident's socks and pink slippers were heavily stained. Interview with LPN #6 on 12/17/07 at 6:45 AM indicated that the resident roamed around the unit during the 11-7 AM shift when awake. LPN #6

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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reported that R #346 had been awake since 4:00 AM and had been roaming the unit. Interview with the MDS Coordinator on 12/19/07 at 11:45 AM indicated awareness of the resident's behavior, however, the care plan failed to address the resident's needs and behaviors.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administration (3) and/or (j) Director of Nurses (2) and/or (s) Social Work (2).

3. Based on clinical record review, facility documentation review and staff interview for one sampled resident with a change in roommate (R #298), the facility failed to notify the resident prior to the roommate change. The findings include:
 - a. Interview with R #298 on 12/17/07 at 2:30 PM indicated a change in roommate had occurred and he/she was not notified prior to the arrival of the new roommate. An interview with the Social Worker on 12/19/07 at 9:30 AM indicated that she did not notify the resident prior to the new roommate being brought into the room. In addition, the Social Worker indicated she was not aware of the facility's notification of roommate change policy because she was new to the facility. Interview with the Director of Social Services (DSW) and review of the resident's bill of rights on 12/19/07 at 10:20 AM identified a right to notify the resident prior to a roommate change. The DSW further indicated the facility did not have a system in place or a policy that directed staff for notification of roommate changes. Licensed Practical Nurse (LPN) #5 in an interview on 12/19/07 at 12:10 PM indicated as a rule, she notifies the resident prior to a roommate change, however, she was not aware of the practice of other staff members.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administration (3) and/or (r) Therapeutic Recreation (1).

4. Based on clinical record reviews, observations and interviews for two of four nursing units reviewed for recreation programs provided to residents with cognitive impairment (R #28, R #187, R #213, R #220 and R #247), and/or for two of two residents newly admitted to the facility, (R #98 and R #362), residents with the facility failed to ensure that activities were identified and/or interventions implemented to meet the residents preferences and interests and/or psychosocial well being and stimulation was provided and/or maintain activity attendance logs. The findings include:
 - a. Resident # 28's diagnoses included dementia. A recreation quarterly assessment dated 8/28/07 (last assessment completed) indicated the resident will come to programs and observe and enjoyed visits from the recreation staff and volunteers. A quarterly Minimum Data Set (MDS) dated 11/9/07 identified impaired short and long-term memory, modified independence for decision making and participated in activities one third to two thirds of the time. The resident care plan dated 11/6/07 identified an alteration in activities with interventions that included providing two out of room

DATES OF VISIT: December 17, 18, 19 and 20, 2007

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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activities every week and providing encouragement and transportation to daily activities. Review of the December 1 through December 20, 2007 activity calendar identified the resident attended one out of room activity and only two in room visits were provided by recreation staff. Review of the recreation progress notes and December 2007 activity log failed to identify the resident was offered and/or encouraged to attend programs. Observations of the resident on 12/19/07 and 12/20/07 at various times of the day failed to identify the resident participated in activity programs. Review of facility recreation documentation and interview with the Director of Recreation on 12/19/07 at 1:30 PM failed to provide evidence additional activity programs and/or socialization was provided to the resident.

- b. Resident #98's diagnoses included acute renal failure, cerebral vascular accident (CVA) and diabetes mellitus. The significant change assessment dated 10/10/07 identified that the resident was severely cognitively impaired, totally dependent on staff for activities of daily living and spent from 1/3 to 2/3 of the time in activities. The assessment identified the resident's general activity pursuit included music and watching television. The care plan dated 10/10/07 identified a need for socialization with interventions that included inviting and encouraging the resident to activities, however, failed to identify individualized interventions to address the resident's activity needs/preferences. Intermittent observations of the resident on 12/17/07 at 10:30 AM, 12/18/07 at 3:15 PM and 4:10 PM, and 12/19/07 at 1:25 PM noted the resident either in bed and/or seated in a custom wheelchair in the corridor outside his/her room. The Activity Attendance Sheet for November 2007 noted nine out of thirty days the resident attended activities. Interview on 12/19/07 at 11:10 AM with the Unit Recreation Staff noted he did not have an activity attendance sheet for December 2007. He noted that he lost the December 2007 activity sheets and was unable to provide evidence the resident received any recreational activity in December 2007.
- c. Resident #187's diagnoses included Alzheimer's disease. The quarterly recreation progress note dated 10/18/07 identified the resident attended programs as an observer, enjoyed birthday parties, music programs, religious services, visits from staff and volunteers and needed daily sensory stimulation. A quarterly Minimum Data Set (MDS) assessment dated 10/19/07 identified impaired short and long-term memory, moderate cognitive impairments for decision making, total dependence for locomotion on and off the unit and participation in activities one third to two thirds of the time. The care plan dated 10/19/07 identified a need for socialization with interventions that included informing, inviting and escorting to daily recreation activities. Review of the December 2007 activity log failed to identify the resident attended any out of room activities. Furthermore, activity log documentation identified the resident received an "in room" visit on three of twenty days. Review of facility recreation documentation and interview with the Director of Recreation on 12/19/07 at 1:30 PM failed to provide evidence additional activity programs and/or socialization was provided to the resident.
- d. Resident #213's diagnoses included Alzheimer's disease. The quarterly recreation progress report dated 8/10/07 (last assessment completed) identified structured activities

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- included music programs, movies and religious services and needed sensory stimulation and socialization. An annual Minimum Data Set (MDS) dated 10/19/07 identified short and long-term memory deficits, rarely made decisions and total dependence for locomotion on and off the unit. Additionally, activity preferences included music, religious activities and watching television. The care plan dated 10/19/07 identified a need for sensory stimulation with interventions that included encouraging and transporting the resident to programs for stimulation and to modify activities so the resident can participate. Review of the December 2007 activity log identified three in-room activities were provided by recreation staff. Furthermore, the log failed to identify the resident attended out of room activities from December 1 through December 19, 2007. Review of facility recreation documentation and interview with the Director of Recreation on 12/19/07 at 1:30 PM failed to provide evidence additional activity programs and/or socialization was provided to the resident.
- e. Resident #220's diagnoses included dementia and Alzheimer's disease. A quarterly recreation progress note dated 8/23/07 identified structured activities that included observing one to two activities per week and was not capable for independent activities. A quarterly Minimum Data Set (MDS) dated 11/2/07 identified short and long-term memory deficits, moderate cognitive impairment, assistance required for locomotion on and off the unit and participation in activities one third to two thirds of the time. The care plan dated 11/2/07 identified cognitive impairment, need for socialization with interventions that included the resident would attend at least two activity programs a week, inform, encourage and transport to daily activities. Although the resident was assessed to be incapable of independent activities, review of the December 2007 activity log failed to identify any out of room activities were offered and/or attended by the resident. Furthermore, the log failed to identify any in room visits were provided by recreation staff. Review of facility recreation documentation and interview with the Director of Recreation on 12/19/07 at 1:30 PM failed to provide evidence additional activity programs and/or socialization was provided to the resident.
- f. Resident #247's diagnoses included dementia. A therapeutic recreation initial assessment dated 7/30/07 (last assessment completed) failed to identify the resident's level of participation in programs, and/or resident leisure interests and/or hobby survey was completed. A quarterly Minimum Data Set (MDS) dated 10/10/07 identified short and long-term memory deficits, moderately impaired decision making abilities, limited assistance for locomotion on and off the unit and participation in activities one third to two thirds of the time. Review of the care plan dated 10/19/07 failed to identify activity interventions were implemented. Review of the December 2007 activity log, facility recreation documentation and interview with the Director of Recreation on 12/19/07 at 1:30 PM failed to provide evidence activity programs and/or socialization was provided to the resident.
- g. Resident #360 was admitted on 11/17/07 and re-admitted on 11/27/07 with a diagnosis of fractured right hip and open reduction with internal fixation (ORIF). The significant change Minimum Data Set (MDS) assessment dated 12/04/07 identified intact short and

DATES OF VISIT: December 17, 18, 19 and 20, 2007

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- long term memory, total assistance for locomotion off the unit and participation in activities one third to two third of the time. The MDS identified activity preferences were music, spiritual/religious activities and watching television. Review of the care plan dated 12/06/07 identified adjustment to new surroundings and orientation with interventions that included one to one room visits. Interview on 12/18/07 at 9:20 AM with the resident failed to identify knowledge of facility activities and was never given an activity calendar. Observations on 12/17/07, 12/18/07 and 12/19/07 at 9:50 AM, 10:30 AM, 10:45 AM, 11:45 AM, 12:12 PM, and/or 1:30 PM noted the resident was in bed and/or sitting in the corridor awake or dozing and/or at Physical Therapy. Interview and review of the activity attendance records on 12/19/07 at 11:10 AM with the Unit Recreation Staff noted he did not have an activity attendance sheet for November 2007 due to personal illness and indicated the December 2007 activity attendance sheets were lost. The Recreation Staff was unable to provide evidence the resident received recreational activity during December 2007.
- h. Resident #362 was admitted to the facility on 11/28/07 with diagnoses that included myelodysplastic syndrome. An admission Minimum Data Set dated 12/5/07 identified intact cognition and total assistance required for locomotion on and off the unit. A Resident Care Conference signature sheet identified care plan meetings occurred on 12/7/07 and 12/14/07. Recreation staff could not locate a December activity attendance log for the resident. Review of the clinical record and facility documentation with the Director of Recreation Therapy on 2/19/07 at 9:50 AM failed to provide evidence an admission recreation assessment and/or comprehensive care plan was developed to address the resident's recreation preferences and needs. The Recreation Director noted the recreation staff member responsible for the resident's unit was on vacation and she could not explain why an admission assessment was not completed and/or a care plan developed.
- i. Review of the third floor November 2007 activity attendance logs on 12/19/07 at 9:00 AM failed to identify fifteen cognitively impaired residents attended out of room activities during the month. Additionally, the December activity attendance records for the third floor were unavailable. The Recreation Staff responsible for the third floor in an interview on 12/19/07 at 10:45 AM indicated the December activity logs were lost around December 12, 2007 and the residents' activity attendance had not been recorded after the log was missing. The Recreation Staff noted residents were provided in room visits, however, were not transported to out of room activities for various reason which included not being out of bed for transport and/or he was on vacation.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administration (3) and/or (k) Nurse Supervision (1).

5. Based on observations and interviews for one of fifty-two sampled residents, (R #365), the facility

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

failed to ensure the temperature in the resident's room was maintained at a comfortable level. The findings include:

- a. Observations on 12/17/07 from 5:30 AM - 8:30 AM noted blankets and plastic hanging over Resident #365's window. Cold air was felt and observed blowing through the window. The resident was observed in the bed with multiple layers of blankets pulled up over the neck and face. Interview with the Resident #365 at 8:30 AM noted that the window had been broken all weekend (for 2 days), and that no one had been in to fix it. Resident #365 stated that he/she had been freezing all weekend. Nurses' notes dated 12/16/07 identified that the room was cold, wind was blowing in, and the resident complained of cold symptoms. The physician was called and ordered Robitussin. Interview with the maintenance employee on 12/17/07 at 8:30 AM noted that the window was off the track, he had just repaired it, and that maintenance was available all weekend to repair the window if it had been reported to them.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(I).

6. Based on review of the clinical record and facility documentation and interview for three of eight sampled residents reviewed for activities (R #247, R #360 and R #362) and/or for one of three sampled residents who utilized a low air loss mattress (R #116) and/or for one sampled resident with a respiratory diagnosis (R #348), the facility failed to ensure a comprehensive care plan was developed. The findings include:
 - a. Resident # 116's diagnoses included cerebral vascular accident with left sided hemiparesis. A significant change Minimum Data Set (MDS) dated 10/18/07 identified impaired cognition, total care for activities of daily living, bladder and bowel incontinence, wound infection, stage IV pressure ulcer and weight 117 pounds. A pressure ulcer risk assessment dated 10/18/07 identified a high risk for pressure ulcer development. The care plan dated 10/18/07 identified alteration in skin integrity due to a pressure ulcer with interventions that included providing repositioning every two hours, bed rest every other day to promote healing, utilization of a Relief Aire low air loss mattress, pillow under the calves for off loading of the heels and incontinent care every two hours. Physician 's orders dated 12/7/07 directed to irrigate the right ischeal pressure ulcer with Normal Saline, pack loosely with a small piece of Iodofoam gauze and cover with a dry dressing once a day. Constant observations on 12/17/07 from 5:10 AM through 8:10 AM (3 hours) identified the Relief Aire mattress pump setting indicated SA for cycle/float setting and 311 pounds for resident weight. Interview with Licensed Practical Nurse (LPN) # 4 on 12/17/07 at 8:40 AM identified the Relief Aire mattress setting was not programmed correctly and she thought it was to be programmed at 10-minute intervals and 120 pounds, the weight of the resident. Review of the care plan and the physician orders with Registered Nurse (RN) # 5 failed to identify interventions were implemented to indicate the required settings for the Relief Aire

DATES OF VISIT: December 17, 18, 19 and 20, 2007

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

mattress.

- b. Resident # 247 was admitted to the facility on 7/20/07 with diagnoses that included dementia. A Minimum Data Set dated 10/10/07 identified moderate cognitive impairment and assistance required for locomotion on and off the unit. A Therapeutic Recreation Initial Assessment dated 7/31/07 indicated the resident was confused and required adjustment to the facility, however, failed to provide evidence the resident's preferences for leisure activity pursuits were obtained. Additionally, a review of the clinical record with the Recreation Director on 12/19/07 at 2:00 PM failed to provide evidence a care plan was established and interventions implemented to address the residents activity needs.
- c. Resident #348's diagnoses included chronic obstructive pulmonary disease and a left lung nodule. The admission Minimum Data Set assessment dated 10/12/07 identified moderately impaired cognition, extensive to total care for activities of daily living and the need for oxygen therapy. A physician order dated 10/10/07 directed to monitor the resident's pulse oximetry (SPO2) every shift and provide oxygen at 2 liters per minute (2 L/M) as needed for shortness of breath and/or an SPO2 of less than 90%. Interview and review of the clinical record with the MDS coordinator on 12/20/07 at 9:40 AM failed to provide evidence a care plan was developed to address the utilization of oxygen and monitoring of the resident's oxygen levels.
- d. Resident #360 was admitted on 11/17/07 and re-admitted on 11/27/07 with a diagnosis of fractured right hip and open reduction with internal fixation (ORIF). The significant change assessment dated 12/04/07 identified intact short and long term memory, required total assistance for locomotion off the unit, and was receiving physical and occupational therapy. The assessment identified the resident was involved in activities one-third to two thirds of the time. Identified activity preferences included music, spiritual/religious activities and watching television. Review of the Therapeutic Recreational Initial Assessment dated 12/06/07 identified the resident will demonstrate adjustment to long term care and orientation (know activity and recreation staff) in the next ninety days, provide one to one visits, welcome to the facility, encourage expression of feeling, introduce to other peers and respect the resident's right to make choices. Review of the care plan dated 12/06/07 and interview on 12/19/07 at 11:10 AM with the Unit Recreation Staff failed to provide evidence a comprehensive care plan was developed and/or interventions implemented to address the resident's activity interests and preferences.
- e. Resident #362 was admitted to the facility on 11/28/07 with diagnoses that included hypertension and osteoarthritis. A Minimum Data Set dated 12/5/07 identified total assistance was required for locomotion on and off the unit, participated in activities one to two thirds of the time and enjoyed religious programs, music, cards, talking and wheeling outdoors. A care plan conference sign in sheet dated 12/14/07 indicated a fourteen-day comprehensive care plan meeting was held. Review of the clinical record with the Recreation Director on 12/19/07 at 9:30 AM failed to provide evidence a recreation care plan was developed within twenty-one days and/or interventions

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

implemented to address the resident's activity needs.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (i) Director of Nurses (2) and/or (o) Medical Records (2)(I) and/or (s) Social Work (2).

7. Based on review of clinical records and staff interviews for one sampled resident receiving hospice services (R #195), and/or for two of fifty-two sampled residents reviewed for timeliness of care plan meetings (R #299 and R #360), the facility failed to revise the care plans, invite the resident and/or conduct a care plan meeting timely. The findings include:
 - a. Resident #195's diagnoses included end stage renal disease. A physician's order dated 7/31/07 directed the resident be evaluated and treated for hospice services. Interview and review of the care plan with Registered Nurse (RN) #6 on 12/20/07 at 10:15 AM identified that, although hospice services had a plan of care in place providing emotional support services twice weekly and a nursing evaluation weekly, the facility did not address the hospice services in the resident's care plan. Further interview identified that RN #6 was not aware of the services that hospice was providing for the resident.
 - b. Resident #299 had diagnosis of hypertension and depression. The quarterly Minimum Data Set (MDS) assessment dated 9/28/07 identified the resident with modified independent decision-making and required limited assistance with activities of daily living. Review of the Resident Care Conference signature sheet on 12/19/07 at 12:45 PM identified the last care plan conference occurred on 7/13/07. Interview and review of the clinical record with the Corporate Nurse on 12/19/07 at 1:00 PM failed to identify that a care plan meeting was held every ninety-two days and/or after the quarterly MDS dated 9/28/07 was completed.
 - c. Resident #360 was re-admitted on 11/27/07 with a diagnosis of fractured right hip and open reduction with internal fixation (ORIF). The significant change Minimum Data Set (MDS) assessment dated 12/04/07 identified intact short and long-term memory. Review of the clinical record noted a Resident Care Conference occurred on 12/6/07. The Signature Sheet identified attendance included the MDS Coordinator and the Unit Recreation Staff Member. The attendance sheet failed to identify the resident and/or family was invited and/or attended the meeting. Interview with the resident on 12/18/07 at 9:15 AM indicated the resident was unaware of the care plan meeting and did not attend. Interview with the MDS Coordinator on 12/19/07 at 1:20 PM noted the facility receptionist mails the Resident Care Conference invitations to the resident and/or family. Interview on 12/20/07 at 9:05 AM with the receptionist and review of the Resident Care Conference Invitations failed to identify R#360 and/or family was notified/invited of the care plan meeting. The receptionist indicated notification of residents is based a list provided by the MDS Coordinator.

DATES OF VISIT: December 17, 18, 19 and 20, 2007

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervision (1).

8. Based on clinical record reviews and interviews for two of three sampled residents with a change of condition (R #210 and R# 348) and/or for one of three sampled resident newly admitted to the facility and at risk for falls (R #360 and R #364), the facility failed to ensure nursing personnel acted within their scope of practice and/or developed an interim plan of care to address the risk of falls. The findings include:
 - a. Resident #210 was re-admitted to the facility on 12/7/07 with diagnoses that included congestive heart failure and diabetes mellitus. Physician's orders dated December 7, 2007 directed to provide oxygen via nasal cannula. A significant change Minimum Data Set assessment dated 12/14/07 identified oxygen used on a daily basis and no pressure ulcers. A nurse's note dated 12/17/07 identified an open area on the left ear and the physician directed to cleanse behind left ear with open area with normal saline followed by Bacitracin twice daily for ten days. Observation of the resident and interview with Licensed Practical Nurse (LPN) #5 on 12/19/07 at 10:25 AM noted the resident with oxygen tubing hooked over both ears. The protective foam over the left ear was missing and noted lying on the bed. LPN #5 indicated the resident often removed the protective foam. Clinical record review and interview with Unit Manager #1 on 12/19/07 at 10:30 AM failed to provide evidence an interim care plan was initiated and/or interventions implemented for prevention of a pressure ulcer from the oxygen tubing. According to Hendrick, Ann et al, Fall Risk Model 2003, once risk factors are identified, nursing interventions should be matched against individual factors to reduce or manage the risk of falling.
 - b. Resident #348 had diagnosis of chronic obstructive pulmonary disease and left lung nodule. The admission assessment dated 10/12/07 identified the resident with moderately impaired cognition, required extensive to total care for activities of daily living and received oxygen therapy. The physician order dated 10/10/07 directed to monitor the pulse oximetry (SPO2) every shift and provide oxygen at 2 liters per minute (2 L/M) as needed for shortness of breath and/or SPO2 less than 90%. Review of the supervisor's nurse's note and respiratory assessment dated 10/30/07 at 1:00 PM identified the resident's SPO2 was 82% and that the resident was receiving 5 L/M of oxygen. Interview and review of the clinical record with the Nursing Supervisor on 12/20/07 at 8:50 A.M. identified that when the supervisor went to assess the resident, the resident was on 5 L/M via mask. Interview with the charge nurse on 12/20/07 at 9:20 AM identified when she entered the room, the resident was not responding and the SPO2 was 82%. She called the Nursing Supervisor to assess the resident and then called the physician. Interview and review of the clinical record with the charge nurse on 12/20/07 at 9:20 AM failed to identify a nurse's note describing the events of the resident's change of condition and/or a physician's order to increase the oxygen flow rate to 5 liters. The charge nurse stated the physician directed to increase the oxygen,

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

however, she forgot to write the order.

- c. Resident #360 was admitted to the facility on 11/17/07 (Saturday) at 12:45 PM with diagnoses that included renal disease, type II diabetes mellitus, paranoia, confusion, hypertension and bipolar disease. The initial nursing assessment dated 11/17/07 identified the resident was confused and required staff assistance for all activities of daily living. The fall risk assessment dated 11/17/07 identified the resident was at high risk for falls. Review of the clinical record noted that there was no interim care plan addressing the resident's risk for falls. Nurse note dated 11/18/07 12:00 PM noted the resident had stated she had lost her balance and fell. The resident was transferred to the hospital. Interview on 12/19/07 at 11:48 AM with the MDS/Care Plan Coordinator and review of the clinical record noted there was no admission care plan addressing the resident's risk for falls. The coordinator noted a blank chart for admission on weekends is available which included care plans to address the resident's interim problems and approaches. She further a plan of care should have been identified on admission. According to Hendrick, Ann et al, Fall Risk Model 2003, once risk factors are identified, nursing interventions should be matched against individual factors to reduce or manage the risk of falling.
- d. Resident #364 was admitted on 12/14/07 with diagnoses that included a left hip fracture on 11/07/07. The Nursing Admission Assessment dated 12/14/07 identified the resident was alert and oriented and required staff assistance for activities of daily living. The Fall Risk assessment dated 12/14/07 identified the resident was a high risk for falls. The Physical Therapy care plan dated 12/15/07 and Occupational Therapy care plan dated 12/17/07 identified problems with decreased mobility and the need for assistance to complete self-care tasks. Review of the clinical record and interview on 12/19/07 at 1:40 PM with the Minimum Data Set (MDS) Coordinator noted the interim care plan dated 12/14/07 was incomplete and did not include interventions to address the residents high fall risk. The MDS Coordinator indicated the Supervisor per facility protocol completes the interim nursing care plan on the weekend. According to Hendrick, Ann et al, Fall Risk Model 2003, once risk factors are identified, nursing interventions should be matched against individual factors to reduce or manage the risk of falling.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(A).

9. Based on clinical record review, and observations for one of nineteen sampled residents at risk for skin breakdown (R#105), the facility failed to ensure that the resident was repositioned at least every two hours in accordance with the plan of care. The findings include:
- a. Resident #105's diagnoses included dementia and incontinence. The quarterly assessment dated 11/21/07 identified that the resident was cognitively impaired, unable to ambulate, was totally dependent on staff for bed mobility and transfers, and was

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

incontinent of bowel and bladder. The care plan dated 11/21/07 identified that the resident was at risk for skin breakdown. Interventions included to turn and reposition every two hours and as needed, use positioning items as ordered, and to monitor skin for signs of breakdown. Constant observations of the resident on 12/17/07 from 6 AM through 9:10 AM noted the resident positioned in bed on the back without the benefit of a position change.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervision (1) and/or (m) Nursing Staff (2)(A).

10. Based on clinical record reviews, observations, review of manufacturers recommendation, and interviews for thirteen of nineteen sampled residents with pressure ulcers and/or at risk for pressure ulcers, (R #s 31, 33, 60, 98, 116, 174, 181, 206, 208, 325, 330, 347 and 365), the facility failed to provide repositioning and/or incontinent care and/or ensure adequate pressure relief was provided to promote healing and/or prevent infection. The findings include:

- a. Resident # 31's diagnoses included dementia, diabetes, gastrostomy tube placement, and a history of a stage IV pressure sore of the coccyx. A Braden scale dated 8/21/07 identified a score of 12 representing a risk for pressure sore development. An assessment dated 11/14/07 identified that the resident was severely cognitively impaired, totally dependent on staff for all activities of daily living, received nutrition via a tube feeding, and had 3 stage two pressure sores. The care plan originally initiated on 10/23/07 with an update on 11/14/07 identified an alteration in skin integrity based on an open pressure sore of the left buttock; the coccyx was not identified in the plan of care. Interventions included pressure-relieving devices to the bed and chair if ordered, and incontinent care every two hours and as needed. Although a Braden scale assessment dated 8/21/07 identified the resident as a risk for pressure ulcer development, review of the care plan failed to provide evidence that a care plan to prevent pressure sores had been developed. Observations on 12/17/07 at 5:30 AM noted the resident in bed with the buttocks/sacral area resting flat on the bed. A very strong urine odor was evident in the resident's room. At 5:45 AM, 2 nurse aides were observed providing incontinent care. The resident had been incontinent of both bowel and bladder. A basin of water was on the bedside stand. No soap or periwash was utilized on the towel used to cleanse the resident's buttocks. A dressing on the coccyx was half off exposing a deep slit; stool was noted on the interior surface of the dressing. When the linen was removed from under the resident, the surveyor observed the disposable brief was completely saturated with yellow color clearly visible throughout the entire brief. A soaker pad that was under the resident was also saturated and had evidence of dark brown, dry urine stains as well as wet areas. Under the soaker pad was a sheet folded in quarters that contained evidence of dry urine stains and wetness as well. The bottom sheet on the resident's bed was also removed and changed, and it too had dry, dark urine stains and wetness. When the incontinent care was completed, barrier cream was applied to the left buttock only.

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The resident was again placed on the back with the sacral area resting on the mattress where the resident remained until 7:40 AM when the day shift nurse aide heard the resident moaning and went in to reposition him/her off of the back. Interview with NA#1 at 6 AM 12/17/07 noted that she had not used soap or periwash to provide incontinent care because the resident had sensitive skin. When asked when the resident had last been provided care/repositioning, she responded at about 3 AM. Constant observations from 5:45 AM through 9:10 AM (period of three hours and twenty five minutes) noted that no licensed staff had entered the room to complete the resident's dressing that was noted off with stool under it. Subsequent to surveyor inquiry, the dressing was changed. Review of wound assessments with the DNS on 12/19/07 at 11:50 AM noted that the pressure sore on the coccyx developed on 12/28/06. On 11/2/07 the coccyx wound measured 0.5cm x 2cm x 0.2 cm in depth. On 12/2/07 the wound measured 0.2cm x 2cm by 1 cm deep. Observations of the wound and assessment with the DNS on 12/19/07 at 11:45 AM noted that the wound actually was a stage III pressure sore measuring 0.4 by 1.4 cm with a depth of 1.2 cm with evidence of bloody drainage. Interview also noted that although the facility had identified pressure sore numbers as being high, no interventions had been put in place to ensure the timely incontinent care and repositioning for resident's at risk for skin breakdown. Further review noted that the nurse assigned to oversee pressure sores, does not assess wounds herself; she just compiles data on a weekly basis.

- b. Resident #33 had diagnoses inclusive of a seizure disorder, mental retardation, and Parkinson's disease. An assessment dated 11/21/07 identified the resident as moderately cognitively impaired and totally dependent on staff for activities of daily living including turning and positioning. A care plan dated 11/24/07 identified the resident to be at risk for skin breakdown with interventions including turning and positioning every two hours. The weekly skin-tracking sheet dated 11/23/07 noted the resident to have a non-healing, Stage II, 2 cm x 1cm open area on the right buttocks. A tracking sheet dated 12/7/07 noted the resident's area to have enlarged to 12cm x 12cm. Observations of the resident noted him/her lying in bed on their back on 12/17/07 at 5:22 a.m. A nurse aide was then observed providing incontinent care. The resident was observed to be incontinent of a moderate amount of urine and had a dressing on the left buttock. The dressing was noted to be partially detached and a large open area could be seen containing a moderate amount of serous drainage. Constant observations from 5:40 a.m. until 9:15 AM noted the resident to be in bed on his/her back without the benefit of repositioning (3 hours 35 minutes). Observation of the resident's buttocks on 12/19/07 at 11:05 noted two open areas on the left buttock measuring 6 cm x 6 cm and 6 cm x 3 cm. The resident was observed lying on an egg crate mattress, which is not recognized as a pressure-relieving device. Interview with Unit Manager at that time identified that the resident should have been repositioned every two hours.
- c. Resident #60 was newly admitted to the facility on 10/3/07 from an acute care hospital with diagnoses that included dehydration, urinary tract infection, multiple MRSA infected pressure sores and other open areas that were debrided and required treatment

DATES OF VISIT: December 17, 18, 19 and 20, 2007

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- with IV Vancomycin. The resident's admission Minimum Data Set (MDS) dated 10/10/07 identified the resident required assistance with hygiene and bed mobility. Wound assessments dated 10/3/07 identified the following pressure sores: stage IV on the left lateral leg, stage IV on the coccyx, stage II on the left Achilles area, stage II on the right posterior leg, stage II on the right hip, and healing bilateral heel pressure sores. A care plan dated 10/3/07 identified an alteration in skin integrity and for staff to provide treatment to the wounds, pressure relieving devices in the bed and chair, turn and reposition every two hours and to notify the physician and family. Weekly wound assessments identified the coccyx pressure sore worsened from 5 cm x 7 cm x 1 cm on 10/3/07 to 11.5 cm x 10.3 cm x 0.8 cm on 10/17/07. Between 10/3/07 and 10/23/07 the coccyx pressure sore was identified with 50% slough and was not necrotic. Review of the resident's clinical record and interview with the DNS on 12/19/07 at 1:40 PM identified that there was no evidence that the physician was notified of the worsening pressure sore.
- d. Resident #98 was admitted on 8/15/07 with diagnoses that included acute renal failure, Cerebral Vascular Accident (CVA), diabetes mellitus, coccyx/right hip pressure ulcer. The assessments dated 8/22/07 and 11/29/07 identified that the resident was cognitively impaired, totally dependent on staff for Activities of Daily Living (ADL), incontinent of bowel and bladder and with a stage IV pressure ulcer. The readmission care plan dated 10/03/07 identified a stage III open wound of the right hip measuring 7.5 cm x 8.0 cm x 3.2 cm with interventions that included to turn and position every two hours and when necessary (PRN). A wound tracking record dated 12/14/07 noted a stage IV, 5.5 cm x 4.6 cm x 0.2 cm right ischeal pressure ulcer. The resident was observed on 12/17/07 at 5:58 AM lying in bed supine with their knees flexed toward the left, a pillow was between the legs but there was no pillow evident at the resident's back to maintain the side lying position. The resident remarked at that time that there was no pillow behind or in front but only between the legs. The resident was noted to be in bed on an alternating air pressure mattress, in the supine position from 5:58 AM to 9:09 AM (3 hours 11 minutes). Although the resident's head of the bed was raised when requested to 50 degrees at 8:11 AM and for breakfast at 8:35 AM, the resident remained in the supine position. Interview on 12/18/07 at 3:15 PM with the Unit Manager noted she was aware that the supine position with the head of the bed up and/or down puts pressure on the sacrum /coccyx and that pressure relief off that position has to be maintained for that same amount of time. She further noted that the resident's position should be changed every two hours and that there was no mechanism to communicate between shifts a schedule to position the resident.
- e. Resident #116's diagnoses included cerebral vascular accident with left sided hemiparesis. A significant change Minimum Data Set (MDS) dated 10/18/07 identified impaired cognition, total care for activities of daily living, bladder and bowel incontinence, wound infection, stage IV pressure ulcer and weight 117 pounds. A pressure ulcer risk assessment dated 10/18/07 identified a high risk for pressure ulcer development. The care plan dated 10/18/07 identified alteration in skin integrity due to

DATES OF VISIT: December 17, 18, 19 and 20, 2007

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

a pressure ulcer with interventions that included providing repositioning every two hours, bed rest every other day to promote healing, utilization of a Relief Aire low air loss mattress, pillow under the calves for off loading of the heels and incontinent care every two hours. Physician's orders dated 12/7/07 directed to irrigate the right ischeal pressure ulcer with Normal Saline, pack loosely with a small piece of Iodofoam gauze and cover with a dry dressing once a day. Constant observations on 12/17/07 from 5:10 AM through 8:10 AM (3 hours) identified R # 116 was in bed positioned on the back without benefit of repositioning and/or incontinent care. Further observation identified the Relief Aire mattress pump setting indicated SA for cycle/float setting and 311 pounds for resident weight. The alert light was noted on and the mattress was noted to be very firm. At 8:15 AM, Nurse Aide (NA) # 3 and # 4 entered the room to provide incontinent care. A taped incontinent brief was noted on the resident and NA # 3 touched the outside of the incontinent brief and stated, "the resident is not wet". Upon surveyor request, the brief was removed to check for incontinence and was noted to be wet with urine. A thick soaker pad and folded draw sheet was under the resident. Upon removal of the incontinent brief, observation noted the stage IV pressure ulcer was without the benefit of a dressing. The dressing was not located in the brief and/or bed. The soaker pad was noted to have a brown incontinent ring and smeared with a small amount of stool. Additionally, the resident's heels were noted on the bed without benefit of off loading. Although Licensed Practical Nurse (LPN) # 4 observed the pressure ulcer lacked a dressing, a new dressing was not applied at the time. Interview with LPN # 4 on 12/17/07 at 8:40 AM indicated she did not apply a dressing to the pressure ulcer because the Treatment Nurse was providing treatments. LPN # 4 further identified the Relief Aire mattress setting was not programmed correctly and was to be programmed at 10-minute intervals and 120 pounds. LPN # 4 indicated the settings were checked at the beginning of the shift and failed to remain constant and she did not know what the SA setting on the pump indicated. LPN # 4 indicated she did not have a chance to call the repair company about the pump. Subsequent observation on 12/19/07 at 11:20 AM noted the resident in bed on his/her back with a johnnie on. The Relief Aire mattress was set at SA for intervals and 311 pounds. The alert light was noted to be on. Interview with Nurse Aide (NA) # 5 on 12/19/07 at 11:20 AM identified morning care had not yet been provided. NA # 5 indicated the resident was positioned on his/her back since breakfast around 8:00 AM, (3 hours and 20 minutes) watching television. NA # 5 provided incontinent care and observation noted the incontinent brief, wound dressing and Iodofoam gauze were soaked with urine and a strong urine odor was noted. A pillow was not positioned under the calves and the heels were not afforded off loading. Registered Nurse (RN) # 5 was notified the resident had been positioned on the back for 3 hours and 20 minutes; the resident was transferred out of bed at 12:20 PM to a wheelchair. Interview with the manufacturers repair representative on 12/19/07 at 2:00 PM identified the company was not aware the facility had a concern with the functioning of the Relief Aire mattress. The representative indicated the mattress functioned by weight and the residents weight is programmed into the pump to ensure adequate

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- pressure relief. With a programmed weight of 311 pounds, the mattress would be very hard for a resident that weighed 117 pounds. Upon examination of the pump system, the repair representative indicated the alert light was on, indicating a problem with the pump and it was not functioning properly. He indicated the repair number was located on the pump and service was available 24 hours a day seven days a week.
- f. Resident #174 was admitted to the facility on 8/16/07 with diagnoses that included dementia and major depression. The initial assessment identified that the resident had 3 stage one and one stage two pressure sores. The quarterly assessment dated 11/13/07 identified that the resident was cognitively impaired, unable to ambulate, required assistance with transfers and activities of daily living (ADL's), was occasionally incontinent of bowel and bladder, and had no pressure sores. The care plan dated 11/6/07 identified that the resident had a two-pressure ulcer of the right buttock. A care plan on 12/7/07 identified a stage two-pressure ulcer of the left buttock. Interventions included to turn and reposition every two hours and as needed, and to use positioning items as ordered. Physician orders dated 11/20/07 directed frequent repositioning in bed. A physician progress note dated 11/20/07 described a coccyx/right buttock wound as 3.5 by 2.2 cm with visible subcutaneous fat. Facility wound documentation dated 11/16/07 identified the wound as 0.3 by 0.8 cm and lacked any description of the wound bed, periwound, and exudate. Facility wound documentation dated 11/23/07 identified that the area had "healed". Wound assessment records identified the presence of a left buttock stage II pressure sore from 11/16/07 through 12/14/07. A right buttock wound developed on 11/9/07, healed on 11/23/07, and reopened 12/14/07. Constant observations on 12/17/07 from 6:10 AM through 9:10 AM (period of three hours) noted that although incontinent care was provided, the resident remained positioned on the buttocks without the benefit of change in position. The resident lacked the benefit of heel floated/elevation throughout the observation period. Interview with RN#4 on 12/17/07 at 7:45 AM noted that although incontinent care and turning/repositioning was to be completed every 2 hours, RN#4 did not have time to monitor/ensure that it was being completed by the nurse aides due to having to care for 60 residents with high acuity on that unit.
- g. Resident #181 had an assessment dated 11/23/07 identifying the resident as severely cognitively impaired and totally dependent on staff for activities of daily living including turning and repositioning. A care plan dated 11/21/07 identified a healed stage two pressure sore on the coccyx with interventions including turning and positioning every two hours. Nursing progress notes dated 12/4/07 identified a reopened stage two pressure sore on the coccyx. Observation of the resident on 12/17/07 from 5:30AM until 8:45AM (a period of three hours and fifteen minutes) noted the resident on his/her back without the benefit of repositioning. Observation of the R#181 on 12/19/07 identified a stage two pressure sore on the coccyx measuring 1.8 centimeter (cm) x 1.3cm. Interview with the Unit Manager at that time identified that the resident should be repositioned every two hours.
- h. Resident #206's diagnoses included paraplegia and hypertension with a history of a

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

non-healing Stage IV pressure sore on the coccyx. The resident's Minimum Data Sets (MDS) dated 10/18/06 through 10/3/07 identified cognitive deficits and the resident required assistance with hygiene and transfers. A Braden risk assessment dated 10/18/06 identified the resident at a moderate risk for skin breakdown. A care plan dated 3/3/07 identified a coccyx wound with interventions that included providing treatment to the wound, pressure relieving devices in the bed and chair and to turn and reposition every two hours. On 6/8/07 Resident #206 was identified with a pus-filled pressure sore on the right heel. Although the resident's care plan was updated to identify the right heel pressure sore and listed interventions that included providing treatments as ordered, use pressure relieving devices, turn and reposition every two hours and measure the wound weekly, the interventions did not identify what pressure relieving devices to use and/or when to use and/or any mechanism for off loading. Between 8/3/07 and 10/5/07 the right heel pressure sore was identified as a stage IV and was necrotic and foul smelling. On 9/7/07 the pressure sore was identified as 4 cm x 3 cm, 50 % necrotic and macerated with yellow/green drainage. By 10/5/07 the pressure sore was identified as 4 cm x 5 cm, 90 % necrotic and macerated with yellow/green drainage. A telephone order on 9/28/07 from MD #1 directed to schedule an appointment at a wound clinic to evaluate Resident #206's right heel pressure sore. R #206 was evaluated in the wound clinic on 10/9/07, identified with gangrene of the right foot and admitted directly to an acute care hospital. Interview with MD #1 on 12/20/07 at 10:40 AM identified that he could not recall if he was notified when R #206's right heel pressure sore worsened. In addition, MD #1 could not recall if he had assessed Resident #206's right heel pressure sore between 6/8/07 and 10/9/07. MD #1 identified that he had not documented any assessments regarding the pressure sore on the coccyx, buttocks or right heel. According to Resident #206's 10/9/07 acute care clinical record, the resident had a 4 cm x 4.5 cm gangrenous lesion of the right heel and had a right below the knee amputation on 10/11/07.

- i. Resident #208 had an assessment dated 12/5/07 identifying the resident was severely cognitively impaired and totally dependent on staff for activities of daily living. A care plan dated 12/5/07 identified that the resident would be free of further breakdown with interventions including turning and positioning every two hours. A wound-tracking sheet dated 12/4/07 identified the resident as having a stage three pressure sore on the coccyx. Observation of the resident on 12/17/07 from 5:40 AM to 8:45 AM (period of two hours and fifty-five minutes) noted the resident positioned on the back without the benefit of repositioning. Observation of the resident's wound on 12/19/07 at 11:30 AM noted a healing stage three-pressure ulcer with 0.8cm open areas noted to be 0.8cm X 0.8cm. Interview with the unit manager at that time identified that the resident should have been turned and repositioned after two hours and not remained on his/her back for three hours and five minutes.
- j. Resident #325's diagnoses included polio, right foot drop, and dementia. The initial/admission assessment dated 6/15/07 identified that the resident was severely cognitively impaired, totally dependent for all activities of daily living, incontinent of

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- bowel and bladder and had 2 stage one-pressure ulcers. The significant change assessment dated 11/21/07 identified that the resident had 2 stage two pressure ulcers. Review of the care plan dated 10/12/07, prior to the development of the pressure ulcer failed to provide evidence that a care plan for prevention of pressure sores had been developed. The care plan dated 11/5/07 identified the presence of a right ankle pressure sore. No interventions were identified related to the location/elimination of pressure to the area. A care plan dated 12/7/07 identified the presence of a coccyx/right buttock pressure sore. Interventions included to turn and position/provide incontinent care every 2 hours, used quilted "booties" to both feet, and not to use pillows for foot elevation. Wound assessment records dated 12/14/07 identified that the resident had Stage II pressure ulcers on the coccyx that developed on 10/30/07, left lateral ankle that developed on 10/31/07, and the right lateral ankle that developed on 11/6/07. Constant observations on 12/17/07 from 6:10 AM to 9:15 AM (period of three hours and five minutes) noted the resident in bed on his/her back without the benefit of repositioning. The resident's heels were resting on the mattress and the feet lacked any pressure relieving devices, although a pillow was placed by the day shift nurse aide under the resident's feet, the heels were not off loaded. Heel lift type boots were noted on the resident's over bed table and were later moved to the bedside stand, but never applied to the resident's feet. Interview with RN#4 on 12/17/07 at 7:45 AM noted that although incontinent care and turning/repositioning was to be completed every 2 hours, RN#4 did not have time to monitor/ensure that it was being completed by the nurse aides due to having to care for 60 residents with high acuity on that unit.
- k. Resident #330 was admitted on 6/20/07 with diagnoses that included Type II Diabetes Mellitus, depression, malnutrition and severe deconditioning. The initial Minimum Data Set (MDS) assessment dated 6/28/07 identified cognitive impairment, extensive to total dependence on staff for activities of daily living (ADL), incontinent of bowel and bladder and without pressure ulcers. The quarterly assessment dated 12/06/07 identified cognitive impairment, total assist for ADL, incontinent of bowel and continent of bladder with a Foley catheter and three stage II pressure ulcers. The care plan dated 12/06/07 identified the resident's Braden Scale Assessment (risk for skin breakdown) was 14 indicating a high risk. The care plan dated 12/07 identified a risk for alteration in skin integrity secondary to fragile skin and/or open areas with open areas to the right and left buttocks and coccyx. Interventions included turn and position every two hours and when necessary (PRN). Wound documentation dated 12/14/07 noted a 2.8 centimeter (cm) x 2.0 cm stage four right ischium pressure ulcer with tunneling noted and a history of healed stage II pressure ulcers of the right and left buttocks and coccyx. Observation on 12/17/07 noted the resident in bed supine (resting on the back) from 5:25 AM until 9:10 AM (period of three hours and forty-five minutes). The resident was noted to have an alternating air pressure mattress on the bed. Although from 7:42 AM to 7:54 AM the Nurse Aide (NA) provided morning care and incontinent care, the resident remained supine in bed with the head of the bed elevated between 30 degrees, 85 degrees and/or 75 degrees. Observation of the wound treatment on 12/17/07 at 10:30 AM noted the

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

presence of a 2.5 cm by 3.0 cm stage four ulcer on the right ischium. Interview on 12/18/07 at 3:15 PM with the Registered Nurse (RN) #5 noted she was aware that supine position with the head of the bed up and/or down puts pressure on the sacrum /coccyx and that to afford pressure relief, the position must be maintained for that same amount of time. She further noted the resident's position should be changed every two hours, however, the facility did not utilize a mechanism to communicate between shifts a schedule to position the resident.

- l. Resident #347's diagnoses included diabetes mellitus, depression, and history of coccyx pressure ulcer. A Minimum Data Set dated 11/07/07 identified the resident with intact memory, absence of behavior symptoms, total dependence for transfers and limited assistance for bed mobility. A care plan dated 12/03/07 identified alteration in skin integrity with interventions that included pressure relieving device to bed and chair, treatment as ordered, and reposition every 2 hours. Observation on 12/19/07 at 10:20 AM identified the resident seated on the bed with Unit Manager #1 indicated a depression in the area of the mattress where the resident was seated. The resident stated a feeling that the mattress was bottoming out and had repeatedly reported the condition to various staff members to no avail. In addition, the resident stated the mattress will reinflate for only 30 minutes after the adjustment was completed, then will deflate thereafter. Upon surveyor inquiry, a service technician was called. Interview with the Service Technician on 12/19/07 at 1:30 PM indicated a replacement mattress was provided due to a leakage problem in the original mattress. Review of the operating manual and interview with the Director of Nurses (DNS) on 12/20/07 at 3:00 PM identified the mattress needed to be in good repair in order to assist in the prevention of pressure ulcers.
- m. Resident #365's diagnoses included stroke, severe malnutrition, delirium, Vancomycin Resistant Enterococcus (VRE) and Clostridium Difficile (C-Diff) in the stool, Methicillin Resistant Staphylococcus Aureus (MRSA) bacteremia and a gastrostomy tube placement. An admission assessment dated 12/7/07 identified the resident had mild cognitive impairment, was totally dependent for all activities of daily living, received nutrition via an enteral feeding tube and had stage two and stage three pressure ulcers. A care plan dated 12/13/07 identified the presence of healing stage three pressure sores on the right buttock and sacrum. Interventions included pressure-relieving devices to the bed and chair, incontinent care and turning and positioning every two hours and as needed. Physician orders dated 12/3/07 directed the application of a protective cream to the coccyx and buttock stage two pressure ulcers twice a day and as needed. Wound assessments dated 12/7/07 identified that R#365's pressure ulcers of the buttocks and coccyx had healed. Observations of R#365 on 12/17/07 from 6:10AM through 9:15 AM noted the resident lying in bed with the sacrum/buttocks flat on the bed. Although pillow-type booties (non-pressure relieving) were in place, the resident's heels were not off-loaded from the mattress. Two nurse aides (CNA) provided incontinent care from 6:40 AM to 6:50 AM. Neither CNA offered or attempted to reposition the resident off his/her back or to off-load the heels from the mattress. R#365 remained in the same

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

position from 6:10 AM through the end of constant observations at 9:10 AM without benefit of repositioning off the buttocks. Interview with Registered Nurse (RN) #4 on 12/17/07 at 7:45 AM indicated that, although incontinent care and turning/repositioning was to be completed every two hours, RN#4 did not have time to monitor/ensure that it was being completed by the CNAs due to the 60 patient case load and high acuity of the residents on the unit.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administration (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervision (1).

11. Based on clinical record review, review of facility documentation and interview for one of two sampled resident who was a new admission to the facility and identified at risk for falls (R #360), the facility failed to implement interventions to address the fall risk and/or prevent a fall and fracture. The findings include:
- a. Resident #360 was admitted to the facility on 11/17/07 (Saturday) at 12:45 PM with diagnoses that included renal disease, type II diabetes mellitus, paranoia, confusion, hypertension and bipolar disease. The initial nursing assessment dated 11/17/07 identified the resident was confused and required staff assistance for all activities of daily living. The fall risk assessment dated 11/17/07 identified the resident was at high risk for falls. Facility documentation dated 11/18/07 at 12:15 PM noted the resident was found by staff sitting on the floor outside of his/her room. The resident stated when turning around, he/she stumbled and fell on their right hip. The resident was transferred to the hospital for evaluation and diagnosed with a right hip fracture that required surgical repair. Interview on 12/19/07 at 1:50 PM with the Nurse Aide who found the resident on 11/18/07 indicated she observed the resident from the hallway trying to make a complete turn and then went "boom" to the floor. Interview and review of the clinical record on 12/19/07 at 11:35 AM with the Unit Manager failed to provide evidence interventions were implemented in the interim care plan to address the resident's risk for falls. The Unit Manager noted that admissions to the facility Sunday through Thursday are discussed the next day at morning report and assessed to determine the plan of care. The Unit Manager noted that when a resident is admitted on the weekend, the Nursing Supervisor is responsible to initiate the plan of care.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administration (3) and/or (j) Director of Nurses (2).

12. Based on clinical record reviews, facility policy review and interviews with staff, the facility failed to ensure that a resident maintain acceptable levels of nutritional status for two sampled residents

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

(Resident #501 and Resident #502) whose therapeutic diets were not determined by a Dietitian.

The findings include:

- a. Resident #501 resided on the facility's 2nd floor and required tube feedings. Resident #501 had diagnoses that included dementia and stroke. Review of the clinical record identified the resident's nutrition assessments from 4/06 to 12/07 were conducted by the Registered Diet Technician (RDT). The clinical record failed to reflect that a Dietitian assessed, monitored or planned for Resident #501's nutritional needs for the 18 month period. The facility policy for nutritional screens and assessments identified a Dietitian was to conduct nutritional assessments and conduct reviews for care planning.
- b. Resident #502 resided on the facility's 2nd floor and required tube feedings. Resident #502 had diagnoses that included Alzheimer's disease and diabetes. Review of the clinical record identified the resident's nutrition assessments from 6/06 to 12/07 were conducted by the Registered Diet Technician (RDT). The clinical record failed to reflect that a Dietitian assessed, monitored or planned for Resident #502's nutritional needs for the 18 month period.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervision (1) and/or (m) Nursing Staff (2)(A).

13. Based on clinical record review and interviews with staff for one of three sampled residents reviewed for proper hydration (R #60), the facility failed to ensure the resident consumed sufficient fluid intake to maintain proper hydration and health. The findings include:

- a. Resident #60 was newly admitted to the facility on 10/3/07 from an acute care hospital with diagnoses that included dehydration, urinary tract infection, multiple MRSA infected pressure sores and other open areas that were debrided and required treatment with IV Vancomycin. The resident's admission MDS (minimum data set) dated 10/10/07 identified the resident required assistance with eating. A Dietitian's assessment dated 10/4/07 identified the resident required 1700 to 1800 cc of fluids each day. Between 10/4/07 and 10/25/07 Resident #60's fluid intake was below 1000 cc on 12 occasions and only attained 1700 cc or more on 1 occasion. On 10/26/07 a feeding tube was inserted at the hospital. Prior to the resident's return to the facility, a Registered Diet Tech (RDT) recommended a tube feeding schedule of Jevity 1.2 at 30 cc per hour around the clock (720 cc per day), flush with 250 cc every shift, and to advance the feeding by 10 cc per hour every 24 hours. Resident #60 returned to the facility following the procedure with instructions from the surgeon to begin using the tube for medication administration and to start tube feedings in 24 hours. LPN #10 obtained telephone orders from MD #2 to follow the recommended tube-feeding plan and to begin the feedings in 24 hours as the surgeon recommended. Resident #60 experienced low fluid intakes of 900 cc of PO (oral) fluids on 10/25/07, 250 cc of fluids via PEG (feeding) tube on 10/26/07, and 650 cc of fluids via PEG tube on 10/27/07. On 10/29/07

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

Resident #60 was admitted to the hospital for treatment of acute renal failure secondary to severe volume depletion and sepsis with a BUN of 229 (normal 6-20), Sodium of 163 (normal 136-145) and Creatinine of 7.2 (normal 0.4-1.1). On arrival to the hospital, Resident #206 was unresponsive and required CPR and intubation. Facility policy identified a RDT could assess, recommend diet needs, and develop nutritional care plans for residents, according to the American Dietetic Association, a Registered Diet Technician can not independently engage in the nutrition care process but could be assigned to tasks that are supervised by a Dietitian. Interview with Dietitian #2 on 12/19/07 at 9:45 AM identified that the RDT's recommended tube feeding amount was too low and should have been started at 40 or 50 cc per hour and advanced by 10 cc per hour every 4 to 8 hours. Dietitian #2 identified that the RDT was assigned to work on the 2nd floor, functioned independently, and was responsible to assess, recommend diet needs and develop nutritional care plans for all the resident's on the 2nd floor. Dietitian #2 identified that she is available to the RDT for questions but has not routinely evaluated RDT's work as she has her own resident assignment. Interview with MD #2 on 12/19/07 at 12:45 PM identified he was not notified on 10/26/07 or 10/27/07 that Resident #60's fluid needs were not met and was not notified of any specific instance where the resident's fluid intake was insufficient. MD #2 identified he would have ordered IV fluids had he been notified. MD #2 also identified that he was not aware that Resident #60's tube feeding recommendations were made by an RDT stating he thought a Dietitian was the one who made the recommendations and expected the recommendations would meet the resident's needs. According to the General Statutes of Connecticut Chapter 384b Dietitian-Nutritionists Sec.20-206m identified that a Dietitian conduct nutritional assessments, develop and implement a nutrition care plan and establish priorities, goals and objectives to meet nutritional needs.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervision (1) and/or (m) Nursing Staff (2)(A).

14. Based on clinical record reviews, observations and interviews for two of four sampled residents with feeding tubes (R #5, R #31 and R#365), the facility failed to ensure proper treatment was provided for residents who required enteral feedings. The findings include:
- Resident #5's diagnoses included diabetes mellitus, aspiration pneumonia, dementia, and cerebrovascular accident. A Minimum Data Set (MDS) dated 11/13/07 identified the resident with long and short term memory problems, moderately impaired cognitive skills, total dependence on staff for all activities of daily living, and use of a feeding tube. A care plan dated 12/09/07 identified a problem of self care deficit with interventions that included to provide assistance with all activities of daily living. The care plan further identified use of a feeding tube with interventions that included the head of bed must be elevated between 30 and 40 degrees around the clock. Observation on 12/17/07 at 5:30 AM identified the resident in bed with the head of the bed elevated

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

less than 30 degrees. Interview with Nurse Aide (NA) #7 at the time indicated the head of the bed was less than 30 degrees because the tube feeding was put on hold 30 minutes prior to incontinent care and assistance was needed to reposition the resident.

Observation with Licensed Practical Nurse (LPN) #6 on 12/17/07 at 5:45 AM noted the head of the bed at 20 degrees. Interview with LPN#6 on 12/17/07 at 5:45 AM indicated the Nurse Aides are directed not to change the setting of the feeding tube and to provide care with the head of the bed elevated greater than 30 degrees.

- b. Resident #31's diagnoses included dementia, diabetes, and gastrostomy tube placement. An assessment dated 11/14/07 identified that the resident was severely cognitively impaired, totally dependent on staff for all activities of daily living, and received nutrition via a tube feeding. The care plan dated 11/14/07 identified the risk for aspiration due to tube feeding around the clock. Interventions included to elevate the head of the bed around the clock. Observations on 12/17/07 at 5:45 AM noted 2 nurse aides providing incontinent care. The head of the resident's bed was flat while the resident was being moved around in the bed and provided with incontinent care. The pump with the tube feeding was noted to be off. After completing the incontinent care, the nurse aide turned the pump back on. Interview with the DNS on 12/18/07 at 3:30 PM noted that the nurse aides are not allowed to turn pumps on and off, and care should be provided with the head of the bed elevated at all times.
- c. Resident #365's diagnoses included stroke, severe malnutrition, delirium, and gastrostomy tube placement. An admission assessment dated 12/7/07 identified that the resident had a mild cognitive impairment, totally dependent on staff for all activities of daily living, and received nutrition via a tube feeding. The initial/admission care plan dated 12/3/07 identified the risk for aspiration due to tube feeding. Interventions included to elevate the head of the bed 30-40 degrees. Observations on 12/17/07 at 6:40 AM noted 2 nurse aides providing incontinent care. The head of the resident's bed was flat while the resident was being moved around in the bed and provided with incontinent care. The pump with the tube feeding was noted to be off. After completing the incontinent care, the nurse aide turned the pump back on. Subsequent to surveyor inquiry, RN#4 directed the nurse aides to never lower the resident's head. Interview with the DNS on 12/18/07 at 3:30 PM noted that the nurse aides are not allowed to turn pumps on and off, and care should be provided with the head of the bed elevated at all times.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administration (3) and/or (j) Director of Nurses (2).

- 15. Based on observations and interviews, the facility failed to ensure that adequate nursing staff was present to provide necessary care to the residents in accordance with their comprehensive plan of care, and/or failed to assess the acuity needs of residents and base staffing needs on the acuity, and/or failed to supervise the activity of the nurse aides to ensure that care was completed in

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

accordance with each individual resident's comprehensive plan of care. The findings include:

- a. Constant observations of resident care on 12/17/07 from 5 AM through 9 AM noted that R #31, R #33, R #98, R #116, R #174, R #181, R #174, R #208, R #365 and R #325 had not received incontinent care and/or repositioning at least every two hours. Further observation during that time noted that nurse aides turned off tube feeding pumps, and lowered the heads of R #31 and R #365 who were receiving enteral feedings on the fourth floor. Interview with the night shift charge nurse for the 4 th floor on 12/17/07 at 6:20 AM noted that she was the only nurse for approximately 60 residents on that shift. She noted that the nurse aides had difficulty getting rounds done every 2 hours, and that she had difficulty supervising the activity of the aides because she was so busy. Subsequent observation on 12/19/07 at 11:20 AM noted R # 116 in bed on their back. Interview with Nurse Aide (NA) # 5 on 12/19/07 at 11:20 AM identified morning care had not yet been provided. NA # 5 indicated the resident was positioned on his/her back since breakfast around 8:00 AM, (3 hours and 20 minutes) watching television. Although Registered Nurse (RN) # 5 was notified the resident had been positioned on the back for 3 hours and 20 minutes, the resident was transferred out of bed at 12:20 PM to a wheelchair. Interview with RN #5 on 12/19/07 at 12:30 PM identified that although staff were inserviced regarding turning, repositioning and providing incontinent care every two hours, monitoring of staff for compliance was not conducted. Interview with the Director of Nurses on 12/20/07 at 10:00 AM identified the facility was aware of issues regarding pressure ulcers in September 2007 and were working towards identifying the route cause. Although inservicing was conducted, monitoring staff for compliance had not been initiated. The DNS indicated the facility had not yet identified the route cause for the problem.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (k) Nurse Supervision (1) and/or (f) Administration (2)(A).

16. Based on clinical record review, observation and interview for one of three sampled residents observed for dressing change (R#330), the licensed nurse failed to sanitize the bandage scissors according to standards of practice. The findings include:
 - a. Resident #330's diagnoses included type II diabetes mellitus, anxiety, depression, malnutrition, hypokalemia, severe deconditioning, hypernatremia, and hyperglycemia. The quarterly assessment dated 12/06/07 identified some cognitive impairment, total assist for activities of daily living, incontinent of bowel and continent of bladder with a Foley catheter and three stage II pressure ulcers. The care plan dated 12/06/07 identified problem of risk for alteration in skin integrity secondary to fragile skin and/or open areas. The care plan noted open areas to the right and left buttock and coccyx. Interventions included treatment as ordered. Wound documentation dated 12/14/07 noted a stage IV wound of the right heel 5.0 cm x 3.0 cm x 0.0 cm necrotic area. Physician ' s order dated 12/14/07 directed to clean the wound with normal saline, pat

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

dry, apply Santyl Ointment and clean dry dressing. Observation on 12/17/07 at 10:55 AM noted the Unit Manager cut the old bandage off the resident's right foot, discarded the dressing which had a small amount of serosanguineous drainage, and placed the bandage scissor off to the side of the treatment field. The licensed nurse continued with the treatment to the wound and was applying the clean gauze/Kling dressing bandage wrap to the foot. The Unit Manager reached for the bandage scissors to assist the licensed nurse to cut the excess Kling dressing. Following surveyor inquiry, the Unit Manager sanitized the scissors before cutting the excess Kling dressing. Interview on 12/20/07 at 9:15 AM with the Infection Control Nurse noted scissors are usually cleaned with Lysol foam after removing dressings.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervision (1) and/or (t) Infection Control (2)(A).

17. Based on clinical record review, observations, and interview for one sampled resident requiring isolation precautions (R#365), the facility failed to ensure that after providing personal care/direct contact with a resident on isolation, that gloves were removed and hands washed before exiting the room. The findings include:
- a. R# 365 was admitted to the facility on 11/30/07 with diagnoses that included Vancomycin Resistant Enterococcus (VRE), Clostridium difficile (C-diff), Methicillin Resistant Staphylococcus Aureus (MRSA) in the urine, and MRSA bacteremia. The care plan dated 11/30/07 identified that the resident required contact precautions due to infections. Observations on 12/17/07 from 6:40 through 6:50 AM noted two nurse aides in the resident's room providing personal care. Both nurse aides donned gowns, gloves, masks and face shields (PPE) prior to entering the resident's room. A "STOP" sign was posted on the door indicating that the resident required isolation precautions. At the completion of the personal care, the nurse aides removed the PPE, and placed it in a trash bag. One nurse aide remained in the room with only gloves on. The nurse aide was observed to place the trash bag on the floor, apply lotion the resident's feet and lower legs, adjust the resident's positioning, pick up the trash bag with the same gloves on, exit the room touching the light switch, and door knob, go down the end of the hall, punch in a code on the biohazard waste door, and dispose of the trash in that room. The aide failed to remove the contaminated gloves and/or wash hands prior to exiting the isolation room. Interview with the infection control nurse on 12/20/07 at 11 AM noted that trash should be bagged and placed into the bin right outside the resident's door, gloves removed, and hands washed prior to exiting isolation room.

DATES OF VISIT: December 17, 18, 19 and 20, 2007

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (k) Nurse Supervision (1) and/or (t) Infection Control (2)(A).

18. Based on clinical record review, observation and interview for two of four sampled residents observed for incontinent care (R #31 and R #330), the nurse aides failed to wash hands between entering residents rooms according to standards of practice. The findings include:
- Observations on 12/17/07 at 5:45 AM noted that after providing incontinent care to R #31 who had been incontinent of bowel and bladder, Nurse Aide (NA) #1 and NA #2 failed to remove gloves and/or wash hands prior to touching multiple objects in the resident's room and bathroom. Facility policy for hand washing directs that gloves be removed and hands washed after providing care.
 - Resident #330's diagnoses included type II diabetes mellitus, anxiety, depression, malnutrition, hypokalemia, severe deconditioning, hypernatremia, and hyperglycemia. The quarterly assessment dated 12/06/07 identified some cognitive impairment, total assist for activities of daily living, incontinent of bowel and continent of bladder with a Foley catheter and three stage II pressure ulcers. Observation on 12/17/07 at 6:09 AM noted the Nurse Aide exited room 318, removed her gloves, went to the linen cart in the hall between room 319 and room 320 and put on new gloves without the benefit of hand washing then entered room 319 and provided care to the resident there. At 6:22 AM the Nurse Aide was observed to exit room 319 discarded the linen and trash in the nearby hampers, remove gloves without the benefit of hand washing. The Nurse Aide donned new gloves from the linen cart and proceeded to room 320 and provided care to the resident there. The procedure was repeated as the Nurse Aide checked if the last resident needed care. Interview on 12/17/07 at 6:45 AM with the Nurse Aide noted she felt she had washed hands every time after the gloves were off and she was aware to wash hands after removing gloves. Interview on 12/20/07 at 9:05 AM with the Infection Control Nurse noted that each resident room has the hand sanitizer in it and it should be used between residents.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (k) Nurse Supervision (1) and/or (t) Infection Control (2)(A).

19. Based on observation and interview for one of four sampled residents observed for incontinent care (R #174), the facility failed to ensure the proper disposal of linen. The findings include:
- Observations on 12/17/07 at 6:10 AM in R#174's room, noted that after providing incontinent care, the nurse aides placed the unbagged dirty linen on the overbed tables and then left the room without cleaning the tables. Interview with the infection control nurse on 12/20/07 at 10:30 AM noted that linen should be placed directly into the hamper outside the door. If placed on the overbed table, the table should be disinfected.

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administration (3).

20. Based on clinical record reviews, review of facility policy, and interviews with facility staff, the facility lacked adequate administration and/or resources to ensure the nutritional health and safety of its residents (R # 60, R #501 and R #502) and/or ensure facility policies were developed and/or implemented to promote healing and/or prevention of pressure ulcers. The findings include:
- a. During the period 4/06 to 12/07, three residents, Residents #60, #501, #502, who required nutritional assessments, the facility failed to ensure the Registered Dietitian assessed and/or provided oversight to the Registered Diet Technician (RDT) relative to the resident's nutritional needs. Although facility policy identified that a RDT could assess, recommend diet needs, and develop nutritional care plans for residents, according to the American Dietetic Association, a Registered Diet Technician can not independently engage in the nutrition care process but could be assigned to tasks that are supervised by a Registered Dietitian. Interview with Dietitian #2 on 12/19/07 at 9:45 AM identified the RDT was assigned to work on the 2nd floor, functioned independently, and was responsible to assess, recommend diet needs and develop nutritional care plans for all the resident's on the 2nd floor. Dietitian #2 identified that she has not routinely evaluating RDT's work and Dietitian #2 covered the 5th and 6th floors while Dietitian #1 covered the 3rd and 4th floors. According to the General Statutes of Connecticut Chapter 384b Dietitian-Nutritionists Sec.20-206m identified that a Dietitian conduct nutritional assessments, develop and implement a nutrition care plan, establish priorities, goals and objectives to meet nutritional needs. Please refer to F157, F325, and F327.
 - b. Interview with the Administrator, Director of Nurses (DNS), and the Quality Assurance Nurse on 12/18/07 at 3:30 PM noted that the facility did not have a positioning plan/policy in place that ensured all residents are repositioned at least every two hours. Interview also noted that although the facility had identified pressure ulcer numbers as being high, no interventions had been put in place to ensure the timely incontinent care and repositioning for resident's at risk for skin breakdown. Further review noted the nurse assigned to oversee pressure ulcers in the facility, does not assess wounds herself, but rather, compiles data on a weekly basis. Although the acuity level for the 4th unit was identified as high, no evaluation of staffing and/or adjustments had been made to compensate for the high acuity. Please refer to F-314.

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (h) Medical Director (2)(F).

21. Based on clinical record reviews, review of facility policies, and interviews, the facility failed to ensure coordination of medical care relative to nutritional oversight and/or nutritional practices for Residents #60, #501, and #502. The findings include:
- a. During the period 4/06 to 12/07, three residents, R #60, #501, #502, who required nutritional assessments, the facility failed to ensure that the Dietitian assessed and/or provided oversight to the Registered Diet Technician (RDT) relative the to the resident 's nutritional needs. Although facility policy identified that a RDT could assess, recommend diet needs, and develop nutritional care plans for residents, according to the American Dietetic Association, a Registered Diet Technician can not independently engage in the nutrition care process but could be assigned to tasks that are supervised by a Dietitian. Interview with Dietitian #2 on 12/19/07 at 9:45am identified that the RDT was assigned to work on the 2nd floor, functioned independently, and was responsible to assess, recommend diet needs and develop nutritional care plans for all the resident's on the 2nd floor. Dietitian #2 identified that she is available to the RDT for questions but has not routinely evaluated RDT's work. Dietitian #2 further identified that she covers the 5th and 6th floors while Dietitian #1 covers the 3rd and 4th floors. Interview with the RDT on 12/20/07 at 12:55pm identified that although he graduated in 5/07 as a Dietitian, he had not completed his internship to become a registered Dietitian. In addition, interview with MD #1 (Medical Director) on 12/19/07 at 10:40 AM identified that the facility did not have a formal process in place to monitor or evaluate consultants, including the 2 Dietitian consultants. According to the General Statutes of Connecticut Chapter 384b Dietitian-Nutritionists Sec.20-206m identified that a Dietitian conduct nutritional assessments, develop and implement a nutrition care plan, establish priorities, goals and objectives to meet nutritional needs. Please refer to F325, F 327.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (1).

22. Based on clinical record reviews, facility policy reviews and interviews for two of fifty-two sampled residents (R #60 and R # 348), the facility failed to ensure the clinical records were complete and accurate. The findings include:
- a. Resident #60 was newly admitted to the facility on 10/3/07 from an acute care hospital with diagnoses that included dehydration, urinary tract infection and multiple infected pressure sores. A Dietitian's assessment dated 10/4/07 identified the resident required 1700 to 1800 cc of fluids each day. Review of the resident's intake and output records between 10/4/07 and 10/25/07 identified a fluid intake under 1000 cc on 12 occasions and 1700 cc or more on 1 occasion. Further review of the Resident's fluid intake records

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

identified staff failed to document the resident's 24-hour fluid intake on 10/10/07, 10/11/07 and 10/12/07 and incompletely documented the intake on 10/13/07. The facility policy for intake and output identified to monitor a resident's fluid intake daily and implement interventions to address fluid deficits. In addition, the facility policy for intake and output identified to complete a hydration assessment if a resident did not meet 1200 cc of fluid in a 24-hour period. On 10/8/07, 10/14/07, 10/15/07, 10/19/07 and 10/20/07 Resident #60 consumed less than 1200 cc and staff failed to conduct a hydration assessment.

- b. Resident #348 had diagnosis of chronic obstructive pulmonary disease and left lung nodule. The admission assessment dated 10/12/07 identified the resident with moderately impaired cognition, required extensive to total care for activities of daily living and received oxygen therapy. The physician order dated 10/10/07 directed to monitor the pulse oximetry (SPO2) every shift and provide oxygen at 2 liters per minute (2 L/M) as needed for shortness of breath and/or SPO2 less than 90%. Review of the supervisor's nurse's note and respiratory assessment dated 10/30/07 at 1:00 PM identified the resident's SPO2 was 82% and that the resident was receiving 5 L/M of oxygen. Interview and review of the clinical record with the Nursing Supervisor on 12/20/07 at 8:50 A.M. identified that when the supervisor went to assess the resident, the resident was on 5 L/M via mask. Interview with the charge nurse on 12/20/07 at 9:20 AM identified when she entered the room, the resident was not responding and the SPO2 was 82%. She called the Nursing Supervisor to assess the resident and then called the physician. Interview and review of the clinical record with the charge nurse on 12/20/07 at 9:20 AM failed to identify a nurse's note describing the events of the resident's change of condition and/or a physician's order to increase the oxygen flow rate to 5 liters. The charge nurse stated the physician directed to increase the oxygen, however, she forgot to write the order.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administration (3).

23. Based on review of facility documentation and staff interviews, the Quality Assurance Committee failed to ensure a system was in place to ensure the repositioning of residents and/or identify the route cause for the high number of pressure ulcers in the facility and/or monitor the effectiveness of their program for pressure ulcers. The findings include:
- a. Interview with the Administrator, Director of Nurses (DNS), and the Quality Assurance Nurse on 12/18/07 at 3:30 PM identified the facility did not have a positioning plan/policy in place that ensured all residents are provided repositioning at least every two hours. Furthermore, although the facility had identified pressure ulcer numbers as high, interventions to ensure the timely incontinent care and repositioning for resident's at risk for pressure ulcer development were not implemented. Subsequent interview with the Director of Nurses on 12/20/07 at 10:00 AM identified the facility was aware of

DATES OF VISIT: December 17, 18, 19 and 20, 2007

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

issues regarding pressure ulcers in September 2007 and were working towards identifying the route cause. Although inservices were conducted, monitoring staff for the effectiveness of the education had not been initiated. The DNS indicated the facility had not yet identified the route cause for the problem.

FLIS Independent Nurse Consultant Guidelines

Relationship between Independent Nurse Consultant (INC) and DPH includes:

- An INC is utilized as a component of DPH's regulatory remedy process. An INC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The INC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The INC's responsibilities include:
 - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
 - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
 - Assessing administration's ability to manage and the care/services being provided by staff.
 - Weekly reporting to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between INC and the Institution:

- The INC maintains a professional and objective relationship with the institutional staff. The INC is a consultant, not an employee of the institution. The INC exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the INC but must cooperate with and respond to requests of the INC related to her fulfilling her/his duties.
- The INC's responsibilities include:
 - Assessment of staff in carrying out their roles of administration, supervision and education.
 - Assessment of institution's compliance with federal/state laws and regulations.
 - Recommendations to institutional administration regarding staff performance.
 - Monitoring of care/services being provided.
 - Assists staff with plans of action to enhance care and services within the institution.
 - Recommendation of staff changes based on observations and regulatory issues.
 - Weekly reports to the institution re: assessments, issues identified, and monitoring of plans of correction.
 - Promotes staff growth and accountability.
 - May present some inservices but primary function is to develop facility resources to function independently.
 - Educates staff regarding federal/state laws and regulations.